MAP-4100

ACQUIRED BRAIN INJURY WAIVER PROGRAM PROVIDER INFORMATIONAND SERVICES

PROVIDER NUMBER _____

NPI (National Provider Identifier) Number _____

AGENCY NAME _____

AGENCY ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COVERED SERVICES (Check all that apply)

☐ Case Management
☐ Personal Care Services
☐ Companion Services
☐ Respite Care
☐ Environmental Modifications
☐ Behavior Programming
☐ Counseling and Training
☐ Structured Day Program
☐ Specialized Medical Equipment and Supplies
☐ Prevocational Services
☐ Supported Employment Services
☐ Community-Residential Services
☐ Occupational Therapy
☐ Speech, Hearing and Language Services

By signing below I, _____, certify that this agency is capable of and agrees to comply with the conditions for participation established in the Acquired Brain Injury Services and Reimbursement Program Manual. In addition, I certify that all staff shall meet all training requirements prior to the provision of services.

_____
Signature of Authorized Representative

_____, _____
Title Date

Please return forms to:
KY Medicaid Provider Enrollment
P.O. Box 2110
Frankfort, KY 40602-2110